

**Chaplaincy: Life in the Hush and the Hurry**

**An Honors Thesis (HONR 499)**

**by**

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**Abstract:**

Hospital chaplaincy is currently and has been historically a vocation that avoids being put into a neat box that describes what chaplaincy is and what chaplains do. Chaplains live in-between the worlds of the secular and the sacred while performing services for others similar to what both counselors and pastors perform. It is in these in-betweens and uncertainties that the chaplain ministers to patients and loved ones in the most vulnerable times of their lives. Through my chaplaincy internship at Ball Memorial Hospital, I was able to experience firsthand how to be present with those in spiritual and emotional need, patients, family members, and staff. I learned about myself, how I interact with others, and most importantly found a vocation that I feel called to pursue. My decision to attend seminary and pursue pastoral ministry in the near future was a direct result of my internship experiences. This paper is an account of my chaplaincy internship experience and an illumination into the state of mind and being that the chaplaincy process implores on its participants.

**Acknowledgments:**

I would like to, first off, thank my advisor and mentor Gary Pavlechko. I would like to thank him for his patience through the whole process of this thesis and for his continuing support and encouragement. Gary has a love for being with and caring for people that I hope to one day match.

I would like to thank the current and past chaplains at Ball Memorial Hospital that made the contents of this paper possible in the first place, Will Grinstead, James Hilleson, Eric Durbin, and Kal Rissman. They have continually shaped me in both my learning and life practice through their continual guidance and the numerous hours of supervision that they have provided for me.

I would also like to thank the two interns that I started the chaplaincy internship with and who took the time to take me under their wings during my uncertainties, Sheryl Maupin and Alex Wallace.

I would like to thank my pastor, Pat Smith, who helped shape my current desire to attend Princeton Theological Seminary under the care of the Whitewater Valley Presbytery of the Presbyterian Church (USA). I hope to continue the self-exploration and self-growth there that started with my hospital chaplaincy internship.

Lastly, I would like to thank my friends and family, especially my Mother, Lydia and Father, Dwight, who have supported me through the ups and downs of this whole process.

**Process Analysis Statement:**

The way that I approached writing and creating this thesis was two-fold. First, I reflected on the chaplaincy internship in which I was took part at Ball Memorial Hospital for my psychology internship requirement. This was a two-semester internship, during the spring and fall of 2017. So, I had many memories and accounts of patient visits, working with staff, learning from the chaplains, and growing more confident in myself to look back on. Second, I also used this thesis to gather both the books that I had read freely alongside the internship and other articles and books pertaining to pastoral care and chaplaincy that inform a reader about the work life and mentality of a chaplain. This included examining many journal articles, some which were quantitative research pieces and others which offered practical insight into aspects of chaplaincy.

A portion of the chaplaincy internship that this thesis is based on was the instances of both group and individual supervision. During these sessions with chaplain James and Kal, I began to explore aspects of myself such as my tendency to be a perfectionist, and that I tend to worry about what others think about me. During these supervision hours, I also explored specific cases and patients I had visited, discussing what had gone wrong and what had gone right. I also had presented a verbatim, which is a script of a patient visit, as I continued to visit patients. Some of the visits that have shaped my personal being I wrote down and detailed, but others still stick out vividly in my mind. I took the opportunity to detail some of these experiences as examples of the chaplain mentality and my continued growth throughout the paper. Part of my thesis process has involved recounting these stories and staying in contact with the chaplains that made these stories possible.



### Chaplaincy: Life in the Hush and the Hurry

I began this paper pursuing the venture of writing how my degree in psychology and internship in chaplaincy has helped prepare me for seminary. However, I soon saw this goal as not reaching far enough. I decided that if I really wanted to show my Ball State experience through a paper, I would need to show how the chaplaincy program specifically has helped prepare me further for life and made me a better person, not just a better person for a future career. College is important to one's mental, spiritual, and physical growth as a young individual, but it does not teach one the importance of death, silence, making mistakes, and giving presence and compassion. Through this paper, I will highlight what chaplaincy is and the skills and actions that are a part of a chaplain's everyday routine. I will show how these skills are not taught by studying but rather by doing and even by messing up along the way. I will show what I have learned and what other chaplains and pastors have learned through similar processes. Through this paper, I will make clear that the experiences that chaplains witness every day and the skills they use every day helps give them a meaningful life as they strive to become a better person. Specifically, chaplaincy has brought meaningfulness to my life as I strive to become a better person by learning through my strengths and weaknesses.

#### **Beginnings**

When I embarked upon my experience at IU Health Ball Memorial Hospital, I knew nothing about chaplaincy from firsthand personal experience and only knew what it was like because my father is a hospice chaplain. Since I was young, I have seen him care for church members and then for those he knew in his role as chaplain. I did not seek out this position at first, but it was suggested to me by the psychology internship coordinator, Kim Taylor, who thought that it would be a great fit for my aspirations. At first, I was very anxious and nervous

about the experience. I had always been in awe of hospitals and the care that was provided there. However, I thought that there would not be a place for me and that I would be inadequate for the position. I still decided to contact the head chaplain, James, and proceed to go to an interview with the three staff chaplains at the time. I was asked some of the following questions:

How will you handle confrontation?

What experience have you had in consoling others during crisis situations?

How comfortable do you feel talking to patients and families by yourself after you shadow us and trained?

Throughout all these questions, I still managed to be ready for what lie ahead for me in the coming months with the chaplaincy program.

### **Silence During the Moment**

My first experience with transitioning from a job shadowing role to making an individual, personal visit was with an older man with chronic pain and trouble breathing whose wife was constantly by his side. I first visited this patient with the head chaplain James. The patient's wife had requested regular chaplain visits due to his worsening condition. His wife had been by his side since marriage and was not going anywhere as she tended to his every need and worried about every new pain that he developed. When I first started visiting patients, the head chaplain James said to me afterwards, "You sure have the silence part of this vocation down!" He was not being condescending and was instead being serious. Chaplaincy involves asking hospital patients and their loved ones a series of spiritual care related questions, yet the essence of chaplaincy involves much more than this. Chaplain visits involve silence when there is a need for silence and words when there is a need for words.



During most of my visits with the patient and his wife, his wife would often spend five to ten minutes talking about her husband's pain, and I simply listened to her. It seemed important for her to confide in me another about her relentless worries. However, after all of this, it was just as important for me to spend minutes of silence with her as our attention and care was focused on her husband. She simply needed someone to share the exacting silence with her as our thoughts were focused on the husband and his needs. I prayed with her also, but only after I felt that I had given her enough time in silence. A similar silent situation happened when I was called in for my first solo on-call experience, as the family happened to be this same husband and wife. The husband had passed away and she was kneeling beside him, family beside her and tissues in hand. I simply needed to acknowledge her presence and the reality of the situation in total silence, with a nod of the head and a hug. I prayed with her and the family, yet the moments of silence in-between, before, and after seemed much more important to both her and me. This type of personal experience has been shared by numerous helping professionals.

Robert Gauger, in a similar case study as my experience, also mentions the importance of silence in chaplaincy.<sup>1</sup> In this case study, he describes a shared experience he had with a caregiver of a patient, who had also cared for the patient's wife until death. In this account, Robert listens to the caregiver, yet at times they both sit in total silence through the patient's strenuous breathing. The chaplain who experienced and wrote the case study did not press the caregiver with questions regarding her peace of mind or mental health. He instead used the inherent silence in the room to cue him into how he was to be *present* for the caregiver.

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1. Robert William Gauger, "The Caregiver: When Silence Speaks Louder than Words," *The Journal of Pastoral Care & Counseling* 66, no. 3-4 (2012): 9.

Another author, Peter Capretto, explains the need for silence in another way. He explains that the silence of a chaplain or other caregiver is proof to the griever of purposeful care even when their grief cannot be fully empathized and understood to properly respond verbally.<sup>2</sup> The chaplain still remains present with the patient and/or family member despite their inability to always verbally recommunicate the grief. This part of silence was difficult for me, partially because I have always felt the need for an answer to every doubt and question that I am asked. This was also evident in the constant searching for the right answer going on in my head, which I had to learn to systematically ignore. Sometimes silence is more important to healing than the right answer.

### **Spiritual Assessment**

After my first few visits with patients and family in the hospital, I got better at inquiring into the patients' lives. One way in which I accomplished this was taught to me by Chaplain Eric Durbin. This was not a method he learned from a textbook or case study but rather a method he learned from real life. This method that he learned was to first observe the hospital room as you enter it or even before you enter it.<sup>3</sup> This might be observing that someone had brought the patient flowers and a balloon that exclaims "Get Well!" or that you notice the patient has no family members or friends posted on their immediate contact board. Eric taught me that these observations and my gut instinct would help me cue into spiritual needs and initiate *small talk*.

The thought of small talk, to me, seemed trivial at first. However, Chaplain Kal Rissman taught me the importance of talking about sports or the weather in order to get to deeper

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2. Peter Capretto, "Empathy and Silence in Pastoral Care for Traumatic Grief and Loss," *Journal of Religion and Health* 54, no. 1 (2015): 340.

3. Eric Durbin, (chaplain at Ball Memorial Hospital), in discussion with the author, February 2017.



discussions with the patient or family member. Chaplain Kal Rissman told me that in order for anyone to trust me with the important areas in their life, they must be comfortable talking about the common and everyday things.<sup>4</sup> I saw this in the development of my relationships with the nurses on the CIC, ICU, and Oncology units. It took a while for them to start coming to me and trusting me with patients that they believed needed pastoral and spiritual care. That required use of small talk and being around the units regularly. The use of small talk comes before any use of a *spiritual assessment*, except with on-call emergency caregiving instances.

One of the many versions of a chaplain's spiritual assessment tool, the one I used the most often as an intern, is called FACT.<sup>5</sup> The acronym FACT Stands for:

Faith

Active

Coping

Treatment plan

A spiritual assessment tool looks at depth into a patient's spiritual and emotional life, finding those areas of concern and possible action plans to follow as a chaplain. F stands for *faith* and many questions can be used to address this area such as "What in life gives you meaning and purpose" or "Do you belong to a faith or church community?". Sometimes, when talking to a patient, they would immediately express to me that they were a Christian believer and believed in Christ as their Savior. This is usually attempted in a way to tell the chaplain, superficially, "I am okay spiritually and only need you to pray or give a blessing."

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4. Kal Rissman, (former chaplain at Ball Memorial Hospital), in discussion with the author, March, 2017.

5. Mark LaRocca-Pitts, "In FACT, Chaplains Have a Spiritual Assessment Tool," Australian Journal of Pastoral Care and Health 3, no. 2 (2009): 10-12.

However, as a chaplain, one needs to go beyond whether the patient is a believer in Christ, God, or another deity but instead search for the meaning behind their faith. An experience with a particular female patient, on hospice respite care, reminds me of the importance of faith not just in the hospital but as a catalyst of life. This lady had lived in the little town of Dunkirk her whole life, and every story she told seemed to involve angrily scolding an individual as if we were back in time and I was that individual. She had kicked out her alcoholic husband at an early age to raise young children on her own and now lived with her daughter, conflict arising enough to warrant respite care in the hospital. However, during our visit she also had me help her read a particular Psalm, Psalm 23. Part of this passage reads, "He makes me lie down in green pastures, he leads me beside still waters, he refreshes my soul."<sup>6</sup> Despite the confrontation and anger she had often faced in life, this woman longed for spiritual peace to bring meaning to her faith.

The next topic in the FACT spiritual assessment is A for *active* which explores whether the patient/loved one is in community with others in their faith, whether they regularly use spiritual resources, and whether others such as a pastor are supporting them through their illness or bereavement.<sup>7</sup> Through this topic, one gets to know whether the patient is in need of spiritual support or emotional support, according to their current religious and spiritual involvement. Being in the hospital can often strain spiritual community and relationships, yet a chaplain can help contact the patient's pastors or spiritual leaders to help lessen this strain. All faith communities look differently: some consist of family members, some church members, and others even the most unlikely contenders.

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6. Psalm 23: 2-3 NIV

7. LaRocca-Pitts, "In FACT, Chaplains Have a Spiritual Assessment Tool," 12.

The third topic is C for *coping* which explores whether the individual is positively or negatively coping with their illness or bereavement and how they are coping with these changes in life.<sup>8</sup> This topic is probably the one that the chaplain spends the most time on with a patient as the patient's actions and conversations help the participant observer understand how they cope. For example, some patients would continue to talk about their physical condition and pain in the hospital while other patients spent the time talking about other people that they cared for and were worried about. Even others concerned themselves about what they emotionally felt and were quick to talk beyond their physical illness.

Pargament examined positive and negative types of religious coping in his 1998 study of several samples including participants who were recovering from an illness in the hospital.<sup>9</sup> Some positive religious coping that was reported being used by participants included seeking religious forgiveness, seeking spiritual support, and spiritual connection. Some negative spiritual coping includes blaming God, believing that God is punishing them or others, re-evaluation of God's powers, and spiritual discontent. The negative coping mechanisms were associated with depression, and emotional distress.<sup>10</sup> Therefore, it is important for the chaplain to be aware of when religion and spirituality are a source of distress for a patient or family member. This is so that the chaplain can explore this topic of distress, its roots, and ways to incorporate positive religious coping into the patient's or family's life.

One instance in which I as a chaplain intern cared for an individual with negative coping strategies started out normal. However, she soon started talking as the Holy Spirit and let me

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8. Ibid., 12.

9. Kenneth I. Pargament, Bruce W. Smith, Harold G. Koenig, and Lisa Perez, "Patterns of Positive and Negative Religious Coping with Major Life Stressors," *Journal for the Scientific Study of Religion* 37, no. 4 (1998): 721. doi:10.2307/1388152.

10. Ibid., 721.



know who it was I was speaking to. That in itself is not negative coping as she was of the Pentecostal tradition, and I might have been convinced of who was talking through her. However, when she was the Holy Spirit, she spoke of God's wrath, how her Grandson, who took care of her, was going to Hell due to his actions. After speaking to the chaplains on staff, they concluded that this was most likely her way of coping with her illness and loss of independence. The palliative care chaplain, Will, was able to work with her closely, later on, in instilling positive religious coping skills and exploring the issue. Soon, I was also able to speak to the patient normally, again, after asking the "holy spirit" to talk to the patient. I then continued to be present with her as I prayed for her illness, attempting to impart positive religious coping.

The last topic in a typical spiritual assessment I would typically conduct with a patient is T for *treatment plan*.<sup>11</sup> Treatment for a patient as a chaplain functions differently than treatment would as a physician or counselor. First off, the role a chaplain provides is seen by chaplains themselves to be one of presence and *being with* patients.<sup>12</sup> For chaplains, this presence is a large part of treatment. However, treatment, in more detail, also can include praying with the individual, exploring grief with an individual, or teaching the patient breathing exercises to help reduce stress. How I would be present with a family member or patient depended on what I had learned about them in the first 10-15 minutes of being with them when I had asked those questions that fit into the first three steps of FACT. Treatment might also include follow-up visits with the patient during their hospital stay.

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11. LaRocca-Pitts, "In FACT, Chaplains Have a Spiritual Assessment Tool," 13.

12. Ellen L. Idler, George H. Grant, Tammie Quest., Zachary Binney, and Molly M. Perkins, "Practical Matters and Ultimate Concerns, 'Doing,' and 'Being': A Diary Study of the Chaplain's Role in the Care of the Seriously Ill in an Urban Acute Care Hospital," *Journal for the Scientific Study of Religion* 54, no. 4 (2015): 723.

One particular visit I completed at the hospital in which multiple visits were necessary was with a patient who was emotional about the possibility of losing her leg due to infection. I was able to visit with her through the whole process of losing her leg and having phantom pains where her leg used to be. With this particular patient, continual visits and prayer were important for her spiritual and emotional well-being as she went through her particular grief, which was the loss of her leg and the possibility of future unrestricted mobility. Along with the variability of what treatment looks like with a particular patient, it is important to remember that the FACT spiritual assessment is one of many mental checklists that should flow naturally into how the chaplain visits their patients. The questions that the chaplain asks should come up naturally through conversation so that the patient should not feel that they are being assessed but should rather sense that they are being cared for through their grief and adjustment.

### **Grief and Loss**

*Grief* is defined as a “neuropsychobiological response to any kind of significant loss.”<sup>13</sup> Many reactions might accompany grief including panic, guilt, anger, anxiety, and loneliness. Each loss is different, and a loss might not necessarily be a loss of a loved one but also could be a loss of mobility, health, routine of living, or limbs. I remember one woman I visited who was in particular grief because her stay in the hospital was keeping her from her husband and dog. Her husband had mobility issues and could not visit her in the hospital. However, it was essential that she stay in the hospital for a week or so in order that her condition would stabilize. She felt the loss of what she had and longed for the simple things that we often take for granted such as privacy and loved ones.

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13. Christine A. Bruce, "Helping Patients, Families, Caregivers, and Physicians, in the Grieving Process," *The Journal of the American Osteopathic Association* 107, no. 12 (2007): ES33.



The phase of grief that I often witnessed as a chaplain intern was shock and disbelief, which is the first stage of grief as understood by Bowlby, Parkes, and Kübler-Ross.<sup>14</sup> This time period often follows the news of the sudden death of a loved one or a new cancer diagnosis. It often takes the body and soul time to adjust to the new reality and a person is unable to successfully accept a new sudden, change. Other steps of grief include searching and yearning, disorganization and despair, and rebuilding and healing.<sup>15</sup> *Searching and yearning* occurs when an individual asks, “Why is this happening?” or “Why me?” Those patients that I visit who are depressed, do not have the will to go on anymore, or who become apathetic and are often in the disorganization and despair phase.<sup>16</sup> The last phase of grief includes those who have moved forward despite their loss and have a new identity that goes past their loss. A chaplain accompanies patients and family at all stages of grief, greeting this life event reaction with *empathy*.

### **Empathy**

When I first started visiting patients in the hospital, I did not know what empathy really meant. Sure, I could listen to and comprehend what it was that the patient was going through, but I never truly understood their pain or the depth and extent of their pain. It took me time to understand that empathy requires feeling compassion and connectedness to an individual whose story is completely different from yours. Will Grinstead, another chaplain, told me that he could not imagine what a certain patient or family member is going through, so he would be honest and

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14. Ibid., ES35.

15. Ibid., ES35.

16. Ibid., ES35.



inform them of this.<sup>17</sup> However, Will often mentions a personal experience, in visits, that he has gone through which allows the patient to know that he cares and can relate to their situation.

The first time that I truly felt that I had passed on empathy was with a young patient, not much older than I, who had been admitted due to an infection that had spread to his blood from his methamphetamine drug use. I could empathize with this patient because of his age even though I could not understand his life and life history, plagued with drug abuse. This is because I saw past what he had or had not done with his life and instead focused on the everyday challenges his life must have with his drug problems and wishes for a better future. He came to trust me with his faith, anxiety, and near-death experiences.

Empathy allows the caregiver *introspection* into the griever's response to death.<sup>18</sup> This also requires the caregiver to be aware of their own feelings regarding death and loss. Through the situations of end-of-life that I witnessed, I was able to grow in my awareness of the finality of death but of also the space for compassion and final goodbyes that end-of-life can allow for the family. From a theological perspective, grief is a symptom not only of loss but of brokenness.<sup>19</sup> Therefore God's love and the expression of this love is expressed through empathy to bring wholeness and connection where there was previously only loss and despair.

Henri Nouwen, in his book *Wounded Healer*, describes a minister who has his own wounds and loneliness in his life yet is able to care for others with loneliness because of this shared humanness.<sup>20</sup> The *wounded minister* is not one who exhibit his wounds and is concerned about superficially telling those he visits but instead a minister who is willing to see his own pain

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17. Will Grinstead, (palliative care chaplain at Ball Memorial Hospital), in discussion with the author, March, 2017.

18. Capretto, "Empathy and Silence in Pastoral Care for Traumatic Grief and Loss," 344.

19. Ibid., 345.

20. Henri Nouwen, *The Wounded Healer* (New York: Doubleday, 1990), 88.

as occurring in all humankind. A chaplain who has come to understand his own brokenness and loneliness is able to help others through his open hospitality.<sup>21</sup> She is able to empathize and allow space for pain, fear, and, doubt instead of attempting to lessen its realness and impact.

### Prayer

Along with silence, spiritual assessment, and empathy, the chaplain's most recognized practice is that of *prayer* and rituals. Prayer is often important to both spiritual and religious patients alike, often even those who have stopped actively practicing religion. Henri Nouwen describes prayer as containing an intimate relationship with God that is difficult to explain and talk about.<sup>22</sup> Often, patients would ask for prayer but would have difficulty explaining what they wanted the chaplain to pray for and how they wanted the chaplain to pray. I learned, through practice, to pray both what is on my mind about the patient and to acknowledge what the patient has verbally and nonverbally expressed during the visit.

Through the chaplaincy internship, I learned to apply time and effort to my own prayers as I communicated and continued a relationship with God. Nouwen also notes that prayer is a paradox, because it both requires serious effort yet is a gift.<sup>23</sup> I am thankful of prayer as a gift of expressing our worries, wants, needs, and praise to God, both when it is silent and aloud. I felt God in the room when I prayed with patients or family members, especially when it seemed that they were both tearful and joyful to have their needs and concerns expressed out in the open. Prayer to the chaplain is as important as the scalpel to the surgeon. Similar to talk therapy for the counselor, it helps the chaplain provide both care and self-care.

### Self-Care

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21. Ibid., 92.

22. Henri Nouwen, *Reaching Out* (New York: Doubleday, 1975), 81.

23. Ibid., 89.



One part of chaplaincy which I feel applies to my life, behind the scenes, is *self-care*.

Self-care is attending to one's spiritual, physical and emotional needs.<sup>24</sup> This practice is important for everyone in their daily lives but specifically applies to chaplains because they devote their time to caring. My second semester interning at Ball Memorial, fall of 2017, I decided to intern whole days instead of half days. It was in the first few months of that semester that I came to understand the concept *compassion fatigue*. Compassion fatigue is characterized as the fear, anger, helplessness, irritability, and worry that can come from caring for others with unresolved grief and needs on a daily basis.<sup>25</sup>

I first experienced what compassion fatigue was secondhand from fellow interns that I worked with during my first semester as an intern. Sheryl Maupin, one of the fellow interns, shared that it was hard for her to stop thinking about and caring for particular individuals she had met after leaving the hospital each day.<sup>26</sup> She often felt shared pain and grief after seeing patients in end-of-life and traumatic events and therefore had a difficult time not taking her work home. I also soon felt these moments especially with patients that I had spent several visits with or who I saw on-call. There are many ways to combat compassion fatigue and I have applied these lessons to other parts of my life as well.

Some ways to practice self-care that were suggested by my supervisor, James, included taking breaks in-between visits in order to practice alone time and mental reflection.<sup>27</sup> I would often do this before or after charting on my visit with the patient. Michael Stuart adds the need

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24. Michael Stuart, "Practicing Contemplation for Healthy Self-Care," *Chaplaincy Today* 28, no. 1 (2012): 33.

25. *Ibid.*, 33-34.

26. Sheryl Maupin, (previous intern at Ball Memorial Hospital), in discussion with the author. March, 2017.

27. James Hilleson, (lead chaplain at Ball Memorial Hospital), in discussion with the author. March, 2017.



for *contemplation* to help renew the spirit, which similarly can be done through quiet, brief moments of prayer and breathing exercises.<sup>28</sup> Personally, I have used reading a daily devotion, prayer, and journaling as my quiet and contemplative moments, inside and outside the hospital. I am also an avid runner and was able to use the time that I ran with my friends every weekday as a chance to reflect on the day, let it go, and become more future oriented.

### Storytelling

When I first began my chaplaincy internship, I would not have been able to tell you the importance of *storytelling*. However, it was my first internship supervisor, Kal, who suggested the importance of storytelling in chaplaincy. Kal is the type of individual who would be content on telling stories every single minute of his life. Kal is especially adept at telling layman and farmer stories that relate to aspects of drug and addictions counseling. One particular story Kal liked to tell, in coping groups on the Psychiatric Unit, was of a backed-up toilet and how that represents what happens when those with addictions do not deal with their feelings by letting them out but instead harbor them inside and deal with them through their drug dependence.

As much as stories are important to tell as a chaplain, they are also important to listen to. Stories help humans make sense of their life and place in the world.<sup>29</sup> I often felt immersed in a patient's everyday life and struggles just after hearing their stories. Thomas Moore wrote, in *Care Of The Soul*, that storytelling provides care for the soul and deeper meaning.<sup>30</sup> As a chaplain, to listen to stories and deeper meaning provides *presence*.

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28. Michael Stuart, "Practicing Contemplation for Healthy Self-Care," 33.

29. Gillian McLean, "An Integrative Professional Theory and Practice Paper: Personal Reflections from the Journey through Clinical Pastoral Education," *The Journal of Pastoral Care & Counseling* 69, no. 4 (2015): 203.

30. Thomas Moore, *Care of the Soul: A Guide for Cultivating Depth and Sacredness in Everyday Life* (New York: HarperPerennial, 1994), 13.

### Presence

Neil Holm explores the term presence and how it relates to chaplaincy, as chaplains tend to use this term abundantly in their work. This one word helps piece together and drive all of the elements of chaplaincy that I have mentioned, so far. One definition of *presence in chaplaincy* is simply “being with others and paying attention to the quality of that being with.”<sup>31</sup> I would agree with this definition even though it only gets at the surface level of the term presence as I have experienced it. Another definition Holm defines at the beginning of his paper is *faith presence* which includes the qualities of openness, respect, sharing, acceptance, invitation, and learning.<sup>32</sup> These qualities are similar to what I have felt when I have received and given presence when visiting people in the hospital as a chaplain. In presence, there is no schedule or agenda when visiting a patient but instead qualities that one hopes to embody and evoke through their visitation of another human being. This was difficult, as a chaplain intern, because the urge to have an agenda due to what a nurse might have said to me about the patient was always present.

Once I was able to get past small talk to become acquainted with a patient, something marvelous often happened. I recount one particular instance of an encounter I had with an older woman who was a patient with pain on a regular basis that did not seem to go away for her. She welcomed the continual support of chaplains while she was in the hospital because of her strong faith in God. Even with her pain, she was able to still tell me her faith story in a way that resonated with me, because we discovered that we both had a passion for song. Through singing the hymn, “It Is Well With My Soul” together, I felt a strong connection to the woman even though I had only known her for a short time. We had created an area of respect, openness, and

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31. Neil Holm, “Towards a Theology of the Ministry of Presence in Chaplaincy,” *Journal of Christian Education* 52, no. 1 (2009): 8.

32. *Ibid.*, 8.



sharing through the shared voice of a song that held meaning for both of us. In that experience, I felt not only present to the patient but also present to and in the presence of God.

The patient, specifically one of faith, will expect for the chaplain to have a connection with God that can be shared with them. Patients and family, especially those who are older and have been raised in a religious tradition, expect certain things out of a pastoral figure's presence, namely God's ear. However, Wayne Oates proposes that chaplains often find the presence of God in the stranger that they are being present with, and that God is not present through any special connection that they possess but instead through the other.<sup>33</sup> The chaplain, specifically a Christian chaplain, sees the presence of Christ in the stranger and their strange circumstances and welcomes them despite this strangeness.<sup>34</sup> Just as so, the patient often welcomes the chaplain into their strange circumstances because they are a stranger and therefore take on a neutral attitude to the patient's predicament, contrary to the attitudes that loved ones might often share. Holm echoes Oates when he mentions that the sense of trust, dependence, and presence experienced by both the chaplain and the patient can be experienced as God's presence by believers and non-believers alike.<sup>35</sup> Those who a chaplain ministers to, or visits, who are not religious can still experience the visit as containing a presence of the "Other."

In another paper, Neil Holm continues on about what being present with the stranger can be like. Martin Buber uses the term *confirmation* as a vital component of being present, which is discovering not just the person but their potentialities and who they can become as well.<sup>36</sup> Therefore, a chaplain's role is similar to Carl Roger's counselor who shows *unconditional*

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33. Wayne Oates, *The Presence of God in Pastoral Counseling* (Dallas: Word, 1986), 60.

34. *Ibid.*, 61.

35. Neil Holm, "Towards a Theology of the Ministry of Presence in Chaplaincy," 17.

36. Neil Holm, "Practising the Ministry of Presence," *Journal of Christian Education* 52, no. 3 (2009): 30.



*positive regard*. What makes chaplain's and their vocation different than counselors is that they inhabit the worlds of both the secular and sacred, serving as religious leaders in a secular institution.<sup>37</sup> Therefore, a chaplain often uses *enlarged thinking* in order to understand the perspective of the other. The chaplain can easily relate feelings of estrangement or invalidated experience.

Being present with others during my chaplaincy internship brought me into experiences where I interacted and talked with everyday people who I normally would have had no interaction with. This taught me to live in the present moment instead of letting my ever-wandering pattern of thought ruin my joy. I was also able to be more of myself instead of projecting my own image of who I want to be, all through the act of present-oriented versus future-oriented thinking.

### **My Journey Within the Four Steps of Embrace**

Within the article by Holm, there are four steps involved in the process of *embrace* with patients and family members. I feel that these steps also aptly describe my experience in the internship as a whole. This concept embrace is figurative and describes my development in the chaplaincy internship as well as a patient visit. The first step of the embrace is that chaplains make a space and a willingness to connect with the other.<sup>38</sup> The chaplaincy internship helped me become more open to speaking to someone I do not know, especially when it does not serve my interests. I overcame my fears of judgement every time I visited someone. When I first started, I especially got a lot of comments on how young I looked and whether I really was a chaplain intern. However, I learned to be open to the patient despite their openness to me.

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37. Ibid., 32.

38. Ibid., 33.

The second step of embrace is waiting, making space, and respecting the patient's boundaries.<sup>39</sup> Part of this was only entering the room if the patient accepted my invitation. Another part of waiting is only going as far as the patient lets me in. I learned that if I was willing to respect boundaries early on, reluctant patients were more willing to share with me later on. I also found that this waiting helped me with all the tasks at the hospital, which all required a substantial amount of patience. Waiting has been difficult for me in the past and I have always detested concerns that were in limbo or in which I had to wait for before resolved. However, experiencing secondhand the waiting that patients and families go through and the waiting in which I participated in have helped calm this fear of *unfinished work*.

The third step of embrace is similar to the gentle hug you would have with someone you know well.<sup>40</sup> This step is where the patient opens up to the chaplain about who they are, and the chaplain reciprocates. This is a time of exploring and making connections. Embracing a patient is broad enough to be shown through actions such as conversation, silence, and hand-holding. Therefore, the term embrace becomes as literal as it is figurative for chaplains. From my own experience, *touch* in chaplaincy is important, especially as a family member might open their arms to hug you or a patient might hold out their hand to hold during prayer. As I embraced the internship and role I played, it became instinctual to use both figurative and literal embrace.

The last step of embrace is stepping back and letting go, by both chaplain and patient.<sup>41</sup> Hospital chaplains do not always have the opportunity to make follow-up visits and must therefore understand this detachment. If the chaplain and patient have embraced, then both will have learned and grown from the shared experience. Yet, they are still separate individuals in

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39. Ibid., 33.

40. Ibid., 33.

41. Ibid., 33.

different roles. Similarly, at the end of my journey at Ball State, I am stepping back so that I can embrace and engage in new opportunities.

### **Future in Seminary and Ministry**

In the fall of 2018, I will attend Princeton Seminary for a three-year Master of Divinity program. It is in this program that I hope to grow theologically and spiritually as I meet new people and encounter new experiences. In this program, I will most likely complete a CPE (Clinical Pastoral Education) program similar to the chaplaincy internship as well as a pastoral ministry internship. Classes will also be offered to me for preparation of ministry. Yet, I will already have the shape and growth from my chaplaincy on which to build and to create new experiences.



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